

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Wicomico

14007

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury (No. Pennala Hospital St. 19 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant of Mrs. Sadie Anderson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE A. O. 5 SINGLE, Single  
MARRIED, WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Dec 26, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, 7 hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Larry Anderson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sadie Weatherley

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Anderson(Address) Salisbury, Md.

15 Filed Dec 27, 1914 N. B. Turner  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1914, to Dec. 27, 1914.

that I last saw h. alive on Dec. 26, 1914.and that death occurred on the date stated above, at 5 A. m.

The CAUSE OF DEATH\* was as follows:

Premature birth (6 1/2 mos)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) D. B. Potts, M. D.Dec. 27, 1914 (Address) Salisbury Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Horton Cemetery Dec 27, 1914

20 UNDERTAKER ADDRESS

J. Stewart Salisbury Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farmhand, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—Homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 1915

BUREAU, V. S.

14008

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 332[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

1 PLACE OF DEATH

County WicomicoVillage or City Parsonsburg (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)2 FULL NAME Clarence Preston Baker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)6 DATE OF BIRTH Oct 15th, 1914  
(Month) (Day) (Year)7 AGE \_\_\_\_\_ yrs. 1 mos. 28 ds. OR \_\_\_\_\_ min. ?  
If LESS than 1 day, \_\_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_9 BIRTHPLACE (State or country) MarylandPARENTS  
10 NAME OF FATHER John William Baker  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Leah Margaret White  
13 BIRTHPLACE OF MOTHER (State or country) Maryland14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) John William Baker  
(Address) Parsonsburg Md15 Filed 12/13, 1914 J. M. B. B. B.  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 12, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1914, to Dec 12, 1914,  
that I last saw him alive on Dec 12, 1914and that death occurred on the date stated above, at 8-15 P. m.

The CAUSE OF DEATH\* was as follows:

Croupous Pneumonia(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.Contributory  
Secondary(Signed) Charles F. B. B., M. D.  
Dec 13, 1914 (Address) Parsonsburg Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Parsonsburg Cemetery 12/13, 191420 UNDERTAKER ADDRESS  
J. R. H. Harlow undards md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrubwif, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU. V. S.

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14009

## 1 PLACE OF DEATH

County

Wicomico

(No.)

Village or City

Salisbury

Parsons Dist.,  
Elizabeth

Registration Dist. No.

333

St.; 5 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

James L. Bennett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Oct 16 1849  
(Month) (Day) (Year)

7 AGE

65 yrs 1 mos 18 ds.

If LESS than  
1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF FATHER

Ebenezer L. Bennett

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sallie Taylor

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. Atwood Bennett

(Address)

Salisbury, Md.

15

Filed

Dec. 4, 1914

May Turner

Deputy REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 4, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY That I attended deceased from

June 1912, to Dec 4, 1914.

that I last saw him alive on Dec 3, 1914.

and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH\* was as follows:

Chronic interstitial nephritis

(Duration) 3 yrs. mos. ds.

Contributory  
Secondary

Pneumonia

(Duration) yrs. mos. ds.

(Signed)

Dec. 4, 1914 (Address) Salisbury, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Creek Cem. Co. Md.

Dec. 6th 11 AM 1914

20 UNDERTAKER

ADDRESS

Geo. C. Hill

Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

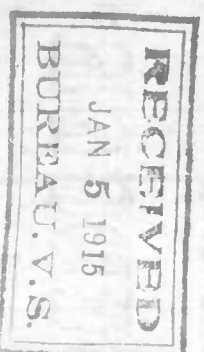
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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14010

## 1 PLACE OF DEATH

County MeconVillage or City Salisbury (No. Parsons list St.; 5 Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alice Brickhead

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH No. no know, 1854  
(Month) (Day) (Year)

7 AGE 60 yrs. mos. ds. 1 day, hrs. min. ?  
OR LESS than 1 day, hrs. min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Va

PARENTS  
10 NAME OF FATHER James Hudson  
11 BIRTHPLACE OF FATHER (State or country) Md  
12 MAIDEN NAME OF MOTHER Pecilla Henry  
13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J. Harmon  
(Address) Salisbury, Md

15 Dec 11 1914 M. Sumner  
Filed REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 10, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1914, to Dec 10, 1914, that I last saw him alive on Dec 9, 1914

and that death occurred on the date stated above, at 8.30 P. m.  
The CAUSE OF DEATH\* was as follows:

Acute Nephritis  
(Duration) yrs. mos. ds.  
Contributory Pneumonia  
Secondary (Duration) yrs. mos. ds.

(Signed) D. B. B. B., M. D.  
Dec. 11, 1914 (Address) Salisbury Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rockawalking Meconico Md DATE OF BURIAL Dec 13, 1914  
20 UNDERTAKER Halloway & Co ADDRESS Salisbury Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercure) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, V. S.



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|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1 PLACE OF DEATH<br><i>Neomisco</i>   |  | 14011 <i>66</i>   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| County <i>Neomisco</i>  |  | Village or City <i>Near Mardela</i>                                       |  | Registration Dist. No. <i>335</i>   |  |
| 2 FULL NAME<br><i>Elizabeth A. Bradley</i>  |  | St.; Ward   |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |   |  |   |  |
| 3 SEX<br><i>Female</i>  | 4 COLOR OR RACE<br><i>White</i>                                  | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <i>Infant</i> |  |   |  |
| 6 DATE OF BIRTH<br><i>Dec 3, 1913</i><br>(Month) (Day) (Year)   |  |   |  |   |  |
| 7 AGE<br><i>11 mos. 29 ds.</i><br>If LESS than 1 day, hrs. OR min. ?  |  |   |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed (or employer)   |  |   |  |   |  |
| 9 BIRTHPLACE<br>(State or country) <i>Sharptown</i>   |  |   |  |   |  |
| PARENTS   | 10 NAME OF FATHER <i>Elmer M. Bradley</i>                        |   |  |   |  |
|   | 11 BIRTHPLACE OF FATHER<br>(State or country) <i>Delaware</i>    |   |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <i>Nannie Wright</i>                    |   |  |   |  |
|   | 13 BIRTHPLACE OF MOTHER<br>(State or country) <i>Neomisco Co</i> |   |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <i>Elmer M. Bradley</i><br>(Address) <i>Delmar, Del #12</i>   |  |   |  |   |  |
| 15 Filed <i>J</i> , 191 <i>4</i>  |  |   |  |   |  |
| REGISTRAR   |  |   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |  |   |  |   |  |
| 16 DATE OF DEATH<br><i>Dec 2, 1914</i><br>(Month) (Day) (Year)  |  |   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <i>one week</i> , 191 <i>3</i> , to <i>Dec 1st</i> , 191 <i>4</i> , that I last saw him alive on <i>Dec 1st</i> , 191 <i>4</i> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:<br><i>Paralysis</i> |  |   |  |   |  |
| Contributory<br>Secondary <i>Bronchitis</i><br>(Duration) yrs. <i>10</i> mos. <i>10</i> ds.   |  |   |  |   |  |
| (Signed) <i>James R. Rogers</i> , M. D.<br><i>Dec 2, 1914</i> (Address) <i>Delmar Del</i>   |  |   |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |   |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death yrs. mos. ds. In the State yrs. mos. ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence   |  |   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><i>Sharptown Md</i> DATE OF BURIAL<br><i>Dec 8, 1914</i>   |  |   |  |   |  |
| 20 UNDERTAKER<br><i>W. D. Gravenor &amp; Bro</i> ADDRESS<br><i>Sharptown</i>  |  |   |  |   |  |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.  |  |   |  |   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for every surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 6 1915

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH   |                 | 14012   |                                      | STATE OF MARYLAND   |  |
|--|-----------------|---|--------------------------------------|---|--|
| County   |                 | Wicomico  |                                      | CERTIFICATE OF DEATH  |  |
| Village or City  |                 | Shaptown  |                                      | Registration Dist. No. 335  |  |
| 2 FULL NAME  |                 | Richard H. L. Bradley   |                                      | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| PERSONAL AND STATISTICAL PARTICULARS   |                 |   |                                      |   |  |
| 3 SEX  | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)  | 16 DATE OF DEATH                     |   |  |
| Male   | White           | Married   | Dec 12, 1914<br>(Month) (Day) (Year) |   |  |
| 6 DATE OF BIRTH  |                 | 17 I HEREBY CERTIFY, That I attended deceased from  |                                      |   |  |
| June 18, 1939<br>(Month) (Day) (Year)  |                 | Oct 21, 1914, to Dec 12, 1914.  |                                      |   |  |
| 7 AGE  |                 | that I last saw him alive on Dec 12, 1914.  |                                      |   |  |
| 75 yrs. 5 mos. 24 ds.  |                 | and that death occurred on the date stated above, at 7 A. m.  |                                      |   |  |
| 8 OCCUPATION   |                 | The CAUSE OF DEATH* was as follows:   |                                      |   |  |
| (a) Trade, profession, or particular kind of work  |                 | Tuberculosis of Bowels  |                                      |   |  |
| (b) General nature of industry, business, or establishment in which employed (or employer) |                 | Farmer.   |                                      |   |  |
| 9 BIRTHPLACE (State or country)  |                 | Contributory Blood maldy  |                                      |   |  |
| Sussex Co. Del.  |                 | Secondary   |                                      |   |  |
| 10 NAME OF FATHER  |                 | (Signed) C. P. Asher, M. D.   |                                      |   |  |
| Richard Bradley  |                 | Dec 13, 1914. (Address) Seaford Del.  |                                      |   |  |
| 11 BIRTHPLACE OF FATHER (State or country)   |                 | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |                                      |   |  |
| Del.   |                 | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)   |                                      |   |  |
| 12 MAIDEN NAME OF MOTHER   |                 | At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.  |                                      |   |  |
| Ophelia Allen  |                 | Where was disease contracted, If not at place of death?   |                                      |   |  |
| 13 BIRTHPLACE OF MOTHER (State or country)   |                 | Former or usual residence   |                                      |   |  |
| Del.   |                 | 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  |                                      |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |                 | Shaptown Md Dec 13, 1914  |                                      |   |  |
| (Informant) Elmer M. Bradley   |                 | 20 UNDERTAKER ADDRESS   |                                      |   |  |
| (Address) Seaford Del  |                 | W. S. Garrow & Bro Shaptown   |                                      |   |  |
| 15 Filed _____, 191_____ REGISTRAR   |                 |   |                                      |   |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-secutal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-tions answered in detail, it will prevent further correspon-dence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 4 1915  
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Wicomico</u>  |   | 14045<br>(28)  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH     |  |
| Village or City <u>Pittsville</u> (No. _____)   |   | St.; _____   |  | Ward _____                                    |  |
| 2 FULL NAME <u>Virgle Thomas Bratten</u>  |   | Registration Dist. No. <u>332</u>  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |  |  |   |  |
| 3 SEX<br><u>male</u>  | 4 COLOR OR RACE<br><u>white</u>                       | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>single</u><br>(Write the word) |  |   |  |
| 6 DATE OF BIRTH<br><u>10 - 26 - 1894</u><br>(Month) (Day) (Year)  |   |  |  |   |  |
| 7 AGE<br><u>20</u> yrs. <u>1</u> mos. <u>20</u> ds.   |   | It LESS than<br>1 day, _____ hrs.<br>OR _____ min. ?                         |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Farming</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) _____  |   |  |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Delaware</u>   |   |  |  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>George W. Bratten</u>            |  |  |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u> |  |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Mariah E. Parsons</u>     |  |  |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u> |  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>George W. Bratten</u><br>(Address) <u>Parsonsburgh, Md.</u>  |   |  |  |   |  |
| 15<br>Filed <u>12/18</u> , 191 <u>4</u> <u>J. Frank Truitt</u><br><u>deputy</u> REGISTRAR   |   |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |   |  |  |   |  |
| 16 DATE OF DEATH <u>Dec. 16</u> , 191 <u>4</u><br>(Month) (Day) (Year)  |   |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,<br>that I last saw him alive on _____, 191____,<br>and that death occurred on the date stated above, at _____ m.<br>The CAUSE OF DEATH* was as follows:<br><u>no doctor.</u><br><u>Tuberculosis</u><br>(Duration) _____ yrs. _____ mos. _____ ds. |   |  |  |   |  |
| Contributory _____<br>Secondary _____<br>(Duration) _____ yrs. _____ mos. _____ ds.   |   |  |  |   |  |
| (Signed) <u>J. Frank Truitt</u><br><u>Pittsville</u><br>(Address)   |   |  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |   |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____   |   |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>M.E. Cemetery</u>   |   |  |  | DATE OF BURIAL<br><u>12/18</u> , 191 <u>4</u> |  |
| 20 UNDERTAKER<br><u>Wm. P. Parsons</u>  |   |  |  | ADDRESS<br><u>Whiterville</u><br><u>Md.</u>   |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Brochopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

14013

County

Delaware

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City Near Delmar (No. Salisbury Dist. St. 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William A. Beston

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

a-a.

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

Oct

21

1860

(Month)

(Day)

(Year)

7 AGE

57

yrs.

2

mos.

7

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

## PARENTS

10 NAME OF FATHER

William Beston

11 BIRTHPLACE OF FATHER (State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Allie Houston

13 BIRTHPLACE OF MOTHER (State or country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Beston

(Address)

Delmar Del.

15

Filed

Dec 28

1914

M. B. Bremer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

12

28

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 1

1914

to

Dec 28

1914

that I last saw him alive on Dec 27, 1914

and that death occurred on the date stated above, at 6.2 a.m.

The CAUSE OF DEATH\* was as follows:

Thrombosis of brain

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

Capitulum &amp; Epistaxis

(Duration)

yrs.

mos.

ds.

(Signed)

H. G. G. G.

M. D.

Dec 28

1914

(Address)

Delmar Del.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Cemetery

Dec 30, 1914

20 UNDERTAKER

ADDRESS

J. F. Stewart

Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

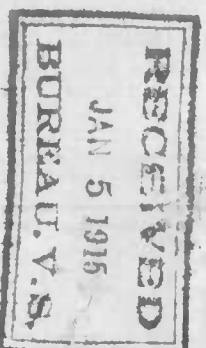
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anacmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential" "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

14014

County

Waconia

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City

Salisbury

(No.

Cameron St. 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William J. Cannon

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED, *married*  
WIDOWED,  
ORDIVORCED  
(Write the word)

6 DATE OF BIRTH

Dec 9<sup>th</sup>, 1841  
(Month) (Day) (Year)

7 AGE

73 yrs. 5<sup>th</sup> ds. OR min. ?  
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

James Cannon

11 BIRTHPLACE OF FATHER  
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Nancy Godfrey

13 BIRTHPLACE OF MOTHER  
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lemuel N. Cannon

(Address)

Salisbury Md

15

Dec 15<sup>th</sup>, 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 14, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1914, to Dec 11, 1914.

that I last saw him alive on Dec 11, 1914.

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH\* was as follows:

Heart  
Attack (Duration) 1 yrs. mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) A. B. Durris, M. D.

Dec 15, 1914 (Address) Salisbury Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rural Cemetery Dec 15, 1914

20 UNDERTAKER

Halloway &amp; Co

ADDRESS

Salisbury Md

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

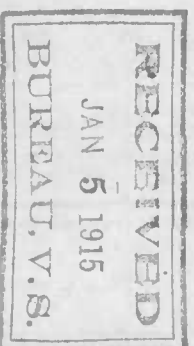
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 14015

County WicomicoVillage or City Wetzel

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 337

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) \_\_\_\_\_

6 DATE OF BIRTH

12 10 1914  
(Month) (Day) (Year)

7 AGE

\_\_\_\_ yrs. \_\_\_\_ mos. 10 ds. OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Louis C. Conway

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Julia Sullivan

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis C. Conway

(Address)

Wetzel Md

15

Filed

Dec 21, 1914 L. T. Walter

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

12 20 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

no physician in attendance

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

L. T. Walter Local Registrar, M. D.  
Dec 21, 1914 (Address) Frankfort, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wetzel Md Dec 21, 1914

20 UNDERTAKER

ADDRESS

C. E. Gussick Baltimore Md

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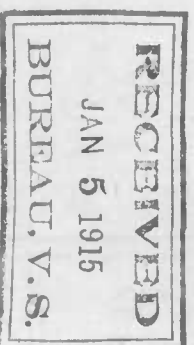
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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## 1 PLACE OF DEATH

County

Wicomico

14016

79

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

337

Village or City

Tosquin

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John T. Doughless

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

1868  
(Month) (Day) (Year)

7 AGE

46 yrs. — mos. — ds. OR 1 day, — hrs. — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Wise Carroll

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ellen Doughless

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary G. Doughless

(Address)

Tosquin Md

15

Filed

Dec 21, 1914 L. J. Haller

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 19, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

May, 1913, to Nov, 1914.

that I last saw him alive on Nov 15, 1914.

and that death occurred on the date stated above, at 8 p.m.

The CAUSE OF DEATH\* was as follows:

Tubercular  
insufficiency of heart.  
in this case.

(Duration) — yrs. — mos. — ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed)

R. E. Caldwell

M. D.

Dec 20, 1914 (Address) Bivaco Md.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tosquin Md Cemetery

Dec 21, 1914

20 UNDERTAKER

ADDRESS

C. G. Merrick

Bivaco Md

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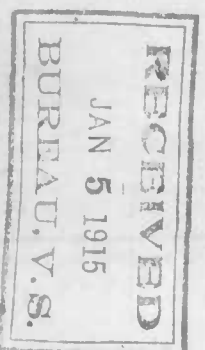
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## 1 PLACE OF DEATH

County Wicomico 14017

(79)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Valstons Switch (No. \_\_\_\_\_, \_\_\_\_\_  
St. 5<sup>th</sup> Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Gosintra Fields

## PERSONAL AND STATISTICAL PARTICULARS

|                        |                                 |   |
|------------------------|---------------------------------|---|
| 3 SEX<br><u>Female</u> | 4 COLOR OR RACE<br><u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Married</u><br>(Write the word) |
|------------------------|---------------------------------|---|

6 DATE OF BIRTH I have no record, 1 \_\_\_\_\_  
(Month) (Day) (Year)7 AGE About 68 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Maryland

|         |   |
|---------|---|
| PARENTS | 10 NAME OF FATHER<br><u>John Taylor</u>                       |
|         | 11 BIRTHPLACE OF FATHER (State or country)<br><u>Maryland</u> |
|         | 12 MAIDEN NAME OF MOTHER<br><u>Banks</u>                      |
|         | 13 BIRTHPLACE OF MOTHER (State or country)<br><u>Maryland</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie Fields  
(Address) Personsbury R. F.D. No. 215 Filed Dec 17, 1914 V. P. Turner  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 16, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1914, to Dec 10, 1914;that I last saw her alive on Nov 2, 1914;and that death occurred on the date stated above, at 3 A m.

The CAUSE OF DEATH\* was as follows:

Mitral regurgitation  
about 1 (Duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
Secondary(Signed) W. B. Burris, M. D.  
Dec 17, 1914 (Address) Salisbury

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Salisbury Wicomico Co. Md. DATE OF BURIAL Dec 18<sup>th</sup> 2 p.m., 191420 UNDERTAKER Geo. L. Hill ADDRESS Salisbury Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

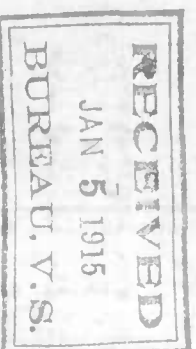
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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14018

1 PLACE OF DEATH *Died in ambulance* STATE OF MARYLAND

County *Accomack* *between R. Y.P.M.R. & P.O. Hospital* CERTIFICATE OF DEATH

Village or City *Salisbury* (No. *92* *Camden St.* St. *18<sup>th</sup>* Ward) Registration Dist. No. *333*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Wm. Thomas Hall*

---

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married* (Write the word)

6 DATE OF BIRTH *Dec 9*, 191*4*  
(Month) (Day) (Year)

7 AGE *About 6* yrs. ☒ If LESS than 1 day, *6* hrs. ☒ OR *6* min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *Farm*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Farming*

9 BIRTHPLACE (State or country) *Accomack Co. Va.*

PARENTS

10 NAME OF FATHER *Mrs. Hall*

11 BIRTHPLACE OF FATHER (State or country) *Accomack Co. Va.*

12 MAIDEN NAME OF MOTHER *Easter Martin*

13 BIRTHPLACE OF MOTHER (State or country) *Accomack Co. Va.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Andrew Hall*  
(Address) *Temperanceville, Va.*

15 Filed *Dec 9*, 191*4* *H. N. Gurner* REGISTRAR

---

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 9*, 191*4*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Dec 9*, 191*4* to *Dec 9*, 191*4*, that I last saw him alive on *Dec 9*, 191*4*, and that death occurred on the date stated above, at *2:45* p. m., The CAUSE OF DEATH\* was as follows:  
*Pneumonia*

(Duration) *7* yrs. *7* mos. *7* ds.

Contributory *Exposure*  
Secondary

(Signed) *M. D.*, M. D.  
*Dec 9*, 191*4* (Address) *Salisbury Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.  
Where was disease contracted *Accomack Co. Va.*  
If not at place of death? *Accomack Co. Va.*  
Former or usual residence *Accomack Co. Va.*

19 PLACE OF BURIAL OR REMOVAL *McKamie Park Va.* DATE OF BURIAL *1914*

20 UNDERTAKER *Shipped By Geo. C. Hill* ADDRESS *Salisbury Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

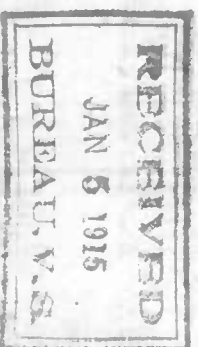
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercleis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septichaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<sup>1</sup> PLACE OF DEATH **14019**  
County Wicomico  
Village or City Delmar (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 336

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup> FULL NAME Willbirth Hearn

## PERSONAL AND STATISTICAL PARTICULARS

|  |  |  |
|--|--|--|
| <sup>3</sup> SEX<br><u>Male</u>  | <sup>4</sup> COLOR OR RACE<br><u>White</u> | <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>S.</u> |
| <sup>6</sup> DATE OF BIRTH<br><u>12</u> / <u>1</u> / <u>1914</u><br>(Month) (Day) (Year)   |  |  |
| <sup>7</sup> AGE<br><u>4</u> yrs. <u>4</u> mos. <u>4</u> ds.   |  | If LESS than 1 day, _____ hrs. OR _____ min. ?                                   |
| <sup>8</sup> OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____ |  |  |
| <sup>9</sup> BIRTHPLACE<br>(State or country) <u>Md.</u>   |  |  |

## PARENTS

|   |
|---|
| <sup>10</sup> NAME OF FATHER<br><u>Carl D Hearn</u>                               |
| <sup>11</sup> BIRTHPLACE OF FATHER<br>(State or country) <u>New Jersey Camden</u> |
| <sup>12</sup> MAIDEN NAME OF MOTHER<br><u>Anna Pearl Goldy</u>                    |
| <sup>13</sup> BIRTHPLACE OF MOTHER<br>(State or country) <u>Camden New Jersey</u> |

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Grayson M.D.  
(Address) Delmar Del

<sup>15</sup> Filed Dec 30, 1914 W. Y. Dunn  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH 12 / 1 / 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h. \_\_\_\_\_, alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Whitlow

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) James Grayson, M. D.  
Dec 1, 1914. (Address) Delmar Del

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence \_\_\_\_\_

<sup>19</sup> PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Delmar

Dec 2, 1914

<sup>20</sup> UNDERTAKER

ADDRESS

Carl D Hearn

Delmar

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

H.N.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

14020

28

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 333

County WicomicoSan Bluff SanitoriumVillage or City New Salisbury(No. Camden Dist St. 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Resco L. Halland

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Oct 29, 1888  
(Month) (Day) (Year)

7 AGE 26 yrs. 1 mos. 7 ds. OR 1 day. hrs. min. ?  
If LESS than 1 day, hrs. min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Horatio S. Halland

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Sannie L. Beachamp

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wayne Halland(Address) Westover Md

15 Dec 7<sup>th</sup>, 1914, W. Farmer  
Filed REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 6, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20<sup>th</sup>, 1914, to Dec. 6<sup>th</sup>, 1914.

that I last saw him alive on Dec. 6<sup>th</sup>, 1914.

and that death occurred on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonalis & Bright's  
(Duration) 2 mos 10 yrs. 10 mos.

Contributory Tuberculosis  
Secondary (Duration) 2 mos 10 yrs. 10 mos.

(Signed) Geo. H. Todd M. D.  
Dec. 7<sup>th</sup>, 1914. (Address) Salisbury Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Westover Sanitorium DATE OF BURIAL Dec 8, 1914

20 UNDERTAKER Hallaway & Co ADDRESS Salisbury Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

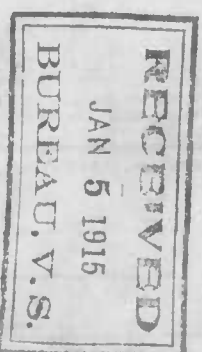
[Approved by U. S. Census and American Public Health Association.]

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## 1 PLACE OF DEATH

County WicomicoParson list

Village or City

Salisbury(No. 313, Broad St.; 5 Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant not named Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

A. A.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Dec101914

(Month)

(Day)

(Year)

7 AGE

head buried

If LESS than 1 day,.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Alonzo Jones

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Lillie King

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alonzo Jones

(Address)

Broad St Salisbury Md

15

Filed Dec 10th, 1914W. S. Sumner

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

from death

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

from deathDec 101914

that I last saw h.....

alive on.....

191.....

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH\* was as follows:

from death

(Duration).....yrs.....mos.....ds.

Contributory  
Secondary

(Duration).....yrs.....mos.....ds.

(Signed)

H. H. Webb

, M. D.

Dec 10, 1914 (Address) Salisbury Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death.....yrs.....mos.....ds.

In the

State.....yrs.....mos.....ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hanston CemeteryDec 11, 1914

20 UNDERTAKER

ADDRESS

J. H. StewartSalisbury Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 1915

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH 13069  
County Miconico

Village or City San Antonio (No. 154) St. \_\_\_\_\_ Ward \_\_\_\_\_

<sup>2</sup> FULL NAME George Washington Menzies

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 331

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Male <sup>4</sup> COLOR OR RACE White <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

<sup>6</sup> DATE OF BIRTH Dec 2, 1841  
(Month) (Day) (Year)

<sup>7</sup> AGE 73 yrs. — mos. 14 ds. It LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

<sup>8</sup> OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

<sup>9</sup> BIRTHPLACE (State or country) Maryland

**PARENTS**  
<sup>10</sup> NAME OF FATHER Nelson Menzies  
<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Maryland  
<sup>12</sup> MAIDEN NAME OF MOTHER Mary Taylor  
<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Maryland

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Herbert Menzies  
(Address) San Antonio MO

<sup>15</sup> Filled \_\_\_\_\_ 191\_\_\_\_  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH Feb 16, 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from Nov 1, 1914, to Dec 16, 1914, that I last saw him alive on Dec 16, 1914

and that death occurred on the date stated above, at 11 P. m.  
The CAUSE OF DEATH\* was as follows:

General Ataxia  
(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. — mos. — ds.

(Signed) J. D. Campbell, M. D.  
12/18, 1914 (Address) San Antonio MO

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

<sup>19</sup> PLACE OF BURIAL OR REMOVAL San Antonio MO DATE OF BURIAL Dec 18, 1914  
<sup>20</sup> UNDERTAKER J. M. Brown ADDRESS San Antonio MO



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

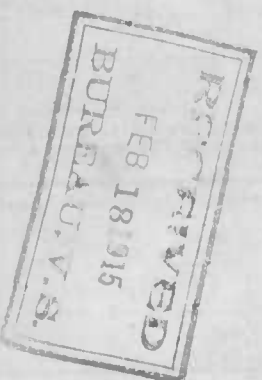
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

14022

County

Mcconnico

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

337

Village or City

Netipquin

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edgar F. Moore

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

colrd

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

July 4, 1910  
(Month) (Day) (Year)

7 AGE

4 yrs. 5 mos. 4 ds. 1 LESS than  
1 day.....hrs.  
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF  
FATHER

William F. Moore

11 BIRTHPLACE  
OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME  
OF MOTHER

Elizabeth Joseph

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William F. Moore

(Address)

Netipquin Md

15

Filed

Dec. 64, 1914 L. P. Spall  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 6, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 25, 1914, to Dec 5, 1914

that I last saw him alive on Dec 5, 1914

and that death occurred on the date stated above, at 1 A. m.

The CAUSE OF DEATH\* was as follows:

Typhoid fever

(Duration) ..... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

R E Caswell, M. D.  
Dec 6, 1914 (Address) Bivans Md.\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-  
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds

Where was disease contracted,  
If not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Netipquin Colb county Dec 7, 1914

20 UNDERTAKER

ADDRESS

C. E. Messick Bivans Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

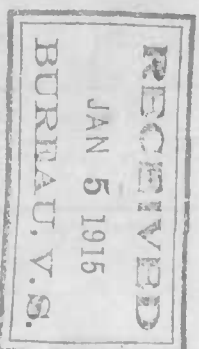
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insultion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

14023

County WicomicoSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 337

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Wetipquin (No. \_\_\_\_\_) St.; Ward \_\_\_\_\_

## 2 FULL NAME

Woodlan Moore

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colord 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH October 21, 1912  
(Month) (Day) (Year)

7 AGE 2 yrs. 1 mos. 26 ds. 1 day, \_\_\_\_\_ hrs. 26 min.?  
OR \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Wicomico Co.

PARENTS  
10 NAME OF FATHER William Francis Moore  
11 BIRTHPLACE OF FATHER (State or country) Wicomico Co.  
12 MAIDEN NAME OF MOTHER Lizzie Joseph  
13 BIRTHPLACE OF MOTHER (State or country) Wicomico Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lizzie Moore Mother(Address) Wetipquin Md

15 Dec 17, 1914 J. J. Walter  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 16, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 13, 1914, to December 16, 1914.

that I last saw him alive on December 16, 1914.and that death occurred on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH\* was as follows:

Pneumonia(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Dr. J. B. Day, M. D.  
December 16, 1914 (Address) Gettersville

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Wetipquin Md DATE OF BURIAL Dec 17, 1914  
Odd Yellow Cemetery

20 UNDERTAKER Ed Robertson ADDRESS Wetipquin

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 5 1915

BUREAU, V.S.



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|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Wicomico</u>  |   | 14024<br><u>P. G. Hospital</u><br>117  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |
| Village or City <u>Salisbury</u>  |   | (No. <u>Camden dist</u> )  |  | Registration Dist. No. <u>333</u>         |  |
| 2 FULL NAME <u>Nellie Nickols</u>   |   |  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |  |  |   |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>White</u>                       | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Single</u><br>(Write the word) |  |   |  |
| 6 DATE OF BIRTH<br><u>Do not know</u><br>(Month) (Day) (Year)   |   | 7 AGE<br><u>18</u> yrs. mos. ds. If LESS than 1 day, hrs. min. ?             |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <u>House work</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)  |   |  |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Del</u>  |   |  |  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>James Nickols</u>                |  |  |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Del</u> |  |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Do not know</u>           |  |  |   |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Del</u>   |   |  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>A. E. Hardesty</u><br>(Address) <u>Bridgetown Del</u>  |   |  |  |   |  |
| 15 <u>Dec 8 1914</u> <u>N. B. Sumner</u><br>REGISTRAR   |   |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |   |  |  |   |  |
| 16 DATE OF DEATH <u>Dec 8</u> , 191 <u>4</u><br>(Month) (Day) (Year)  |   |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Nov. 22</u> , 191 <u>4</u> , to <u>Dec. 8</u> , 191 <u>4</u> , that I last saw her alive on <u>Dec. 8</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>7:45</u> A. M.   |   |  |  |   |  |
| The CAUSE OF DEATH* was as follows:<br><u>General Peritonitis</u>   |   |  |  |   |  |
| Contributory (Duration) yrs. mos. ds. <u>Criminal abortion</u>  |   |  |  |   |  |
| Secondary (Duration) yrs. mos. ds. <u>Dec. 8</u> , 191 <u>4</u> (Address) <u>Salisbury Del</u>  |   |  |  |   |  |
| (Signed) <u>M. D.</u>   |   |  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |   |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death yrs. mos. ds. <u>16</u> In the State <u>Lifelong</u><br>Where was disease contracted, <u>Caroline Co. Md</u><br>If not at place of death?<br>Former or usual residence <u>Hickman, Caroline Co. Md</u> |   |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Todd's Kent Co Del</u> DATE OF BURIAL <u>Dec 10</u> , 191 <u>4</u>   |   |  |  |   |  |
| 20 UNDERTAKER <u>Balloumager &amp; Co</u> ADDRESS <u>Salisbury Md</u>   |   |  |  |   |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for "which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 5 1915  
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Wicomico</u>   |   | 14025<br>(28)  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH     |  |
| Village or City <u>Antietam</u> (No. _____)  |   | St.; _____ Ward _____  |  | Registration Dist. No. <u>337</u>             |  |
| 2 FULL NAME <u>Ida C. Nutter</u>   |   |  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |  |  |   |  |
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>C</u>                                   | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Married</u> |  |   |  |
| 6 DATE OF BIRTH<br>_____, 18 <u>78</u><br>(Month) (Day) (Year)   |   |  |  |   |  |
| 7 AGE<br><u>36</u> yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. OR ____ min. ?  |   |  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <u>Kanscheper</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) _____   |   |  |  |   |  |
| 9 BIRTHPLACE<br>(State or country) <u>Maryland</u>   |   |  |  |   |  |
| PARENTS  | 10 NAME OF FATHER<br><u>John Evans</u>                        |  |  |   |  |
|  | 11 BIRTHPLACE OF FATHER<br>(State or country) <u>Maryland</u> |  |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER<br><u>Elizabeth Evans</u>            |  |  |   |  |
|  | 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>Maryland</u> |  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Geo. W. Nutter</u><br>(Address) <u>Antietam</u>   |   |  |  |   |  |
| 15 Filed <u>Dec 5th, 1914</u> <u>L. J. Walter</u><br>REGISTRAR   |   |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |   |  |  |   |  |
| 16 DATE OF DEATH <u>Dec 4</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |   |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Oct</u> , 191 <u>4</u> , to <u>Dec 4</u> , 191 <u>4</u><br>that I last saw <u>her</u> alive on <u>Dec 2</u> , 191 <u>4</u><br>and that death occurred on the date stated above, at <u>8:40 A.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Tuberculosis of Lungs</u><br>(Duration) <u>1</u> yrs. ____ mos. ____ ds. |   |  |  |   |  |
| Contributory<br>Secondary<br>(Duration) ____ yrs. ____ mos. ____ ds.   |   |  |  |   |  |
| (Signed) <u>J. K. Warner</u> , M. D.<br><u>Dec 4</u> , 191 <u>4</u> (Address) <u>Antietam, Md.</u>   |   |  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |   |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.<br>Where was disease contracted, If not at place of death? _____<br>Former or usual residence _____  |   |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Antietam Col'd Cemetery</u>  |   |  |  | DATE OF BURIAL<br><u>Dec 6</u> , 191 <u>4</u> |  |
| 20 UNDERTAKER<br><u>C. G. Merriam</u>  |   |  |  | ADDRESS<br><u>Bivalve</u>                     |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Soleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the misadventure, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the misadventure causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, surgical, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 1915

BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Wicomico 13019 66  
 near Parsonsbury  
 Village or City on the farm (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward)

## 2 FULL NAME

Louisa A. Parker

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 332

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX See male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
 (Write the word)

6 DATE OF BIRTH \_\_\_\_\_  
 (Month) Aug (Day) 28 (Year) 1847

7 AGE \_\_\_\_\_  
 If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_  
 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR \_\_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work house wife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country)

Maryland

## PARENTS

## 10 NAME OF FATHER

Ely Workman

11 BIRTHPLACE OF FATHER  
(State or country)

Del

## 12 MAIDEN NAME OF MOTHER

Milly Love

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. J. Parker

(Address) Salisbury Md

15

Filed 1/2

1915 J. Frank Priddy  
Deputy REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 1, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1914, to Dec 1, 1914.

that I last saw him alive on Nov 30, 1914

and that death occurred on the date stated above, at 8 p. m.

The CAUSE OF DEATH\* was as follows:

Paralysis  
from pneumonia  
 (Duration) since Oct 1-4 yrs. mos. ds.

Contributory  
 Secondary

Paralysis  
 (Duration) \_\_\_\_\_ yrs. mos. ds.

(Signed)

T. D. Crowder

M. D.

Dec 2, 1914 (Address) Salisbury Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Parkers home burial ground 12/3, 1914

## 20 UNDERTAKER

## ADDRESS

J. Rattiff Harlow unlards md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

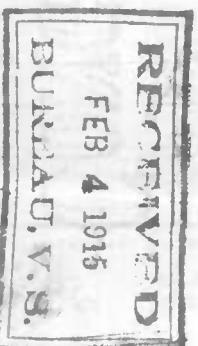
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrubw*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 3020

County

Wicomico

(66)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 332

Village or City

Willards

(No. \_\_\_\_\_)

R.F.D. #1

St. \_\_\_\_\_

Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Martha Anne Parker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

January Third, 1866  
(Month) (Day) (Year)

7 AGE

48 yrs. 11 mos. 18 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmers wife

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Hiram J. Dennis

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Littleton

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mattie E. Parker

(Address)

Willards, Md.

15

Filed

1/2

1912

J. Franklyn Dwyer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 21, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 15, 1914, to Dec 20th, 1914.

that I last saw her alive on Dec 20th, 1914.

and that death occurred on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Hemiplegia - left

(Duration) yrs. mos. 6 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

Dec 21, 1914. (Address) Littleton, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Littleton, Md. 12/22, 1914

20 UNDERTAKER

ADDRESS

J. K. Farlow Littleton, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

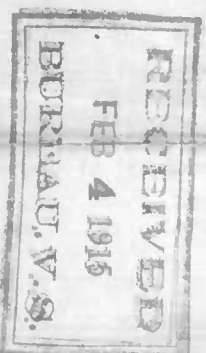
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH 14026

County

Wicomico

66

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City

Pittsville

(No.

Main

St.

Ward)

FULL NAME

Isack Parsons

## PERSONAL AND STATISTICAL PARTICULARS

SEX

male

COLOR OR RACE

White

SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

Married

DATE OF BIRTH

Not known

(Month)

(Day)

(Year)

AGE

90

yrs.

mos.

ds.

IF LESS than  
1 day.....hrs.  
OR.....min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer, retired 10 years

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(State or country)

Maryland Eastern Shore

PARENTS

NAME OF FATHER

Parsons

BIRTHPLACE OF FATHER  
(State or country)

Not known

MAIDEN NAME OF MOTHER

Not known

BIRTHPLACE OF MOTHER  
(State or country)

Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Delia Palmer

(Address)

Pittsville, Md.

Filed

10/11

1914

J. Reginald Jones

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

12

9

1914

(Month)

25

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 25

1914

to

Oct 25

1914

that I last saw him alive on

Oct 25

1914

and that death occurred on the date stated above, at

2 A

m.

The CAUSE OF DEATH\* was as follows:

(Left) Hemiplegia

(Duration)

yrs.

mos.

15 ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Dre 2 / 1914

(Address)

L. C. Green, M. D.  
Pittsville, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Farlow's burial

burial ground

12/11, 1914

20 UNDERTAKER

J. R. Karlan

ADDRESS

untarls

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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RECEIVED  
JAN 5 1915  
BUREAU, V. S.



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| 1 PLACE OF DEATH   |  |  | 14027                                       |  | 154               |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
|--|--|--|---|--|-------------------|--|---|--|
| County <u>Wicomico</u>   |  |  |   |  |                   |  | Registration Dist. No. <u>333</u>   |  |
| Village or City <u>Salisbury Md.</u>   |  |  | (No. <u>Cor. Washella St. Poplar Hall</u> ) |  | St. <u>5</u> Ward |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| 2 FULL NAME <u>Theodosia Parsons</u>   |  |  |   |  |                   |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |  |   |  |                   |  |   |  |
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>White</u>                            | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>married</u> |   |  |                   |  |   |  |
| 6 DATE OF BIRTH<br><u>April 20th</u> , 1885  |  | (Month) (Day) (Year)   |   |  |                   |  |   |  |
| 7 AGE<br><u>79</u> yrs. <u>8</u> mos. <u>5</u> ds.   |  | If LESS than 1 day, ... hrs. OR ... min. ?                                 |   |  |                   |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Housewife</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |  |  |   |  |                   |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Maryland</u>  |  |  |   |  |                   |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>James Carney</u>                      |  |   |  |                   |  |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |  |   |  |                   |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Eleanor Hooks</u>              |  |   |  |                   |  |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> |  |   |  |                   |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |  |  |   |  |                   |  |   |  |
| (Informant) <u>E. J. Parsons</u>   |  |  |   |  |                   |  |   |  |
| (Address) <u>801 Poplar Ave Salisbury Md</u>   |  |  |   |  |                   |  |   |  |
| 15 <u>Dec 26</u> , 1914 <u>N. P. Turner</u>  |  |  |   |  |                   |  |   |  |
| REGISTRAR  |  |  |   |  |                   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |  |  |   |  |                   |  |   |  |
| 16 DATE OF DEATH <u>Dec 25th</u> , 1914<br>(Month) (Day) (Year)  |  |  |   |  |                   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 31</u> , 1913 to <u>Dec 23</u> , 1914,<br>that I last saw him alive on <u>Dec 23</u> , 1914,<br>and that death occurred on the date stated above, at <u>5 A</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>General debility</u><br><u>Old age</u><br>(Duration) ... yrs. ... mos. ... ds.<br>Contributory <u>Diabetes</u><br>Secondary<br>(Duration) ... yrs. ... mos. ... ds.<br>(Signed) <u>O. R. Smith</u> , M. D.<br><u>Dec 26</u> , 1914 (Address) <u>Salisbury Md</u> |  |  |   |  |                   |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |  |   |  |                   |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence  |  |  |   |  |                   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Parsons Cem. Salisbury Md.</u> DATE OF BURIAL <u>Dec 27th</u> 1914  |  |  |   |  |                   |  |   |  |
| 20 UNDERTAKER <u>Geo. C. Hill</u> ADDRESS <u>Salisbury Md.</u>   |  |  |   |  |                   |  |   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

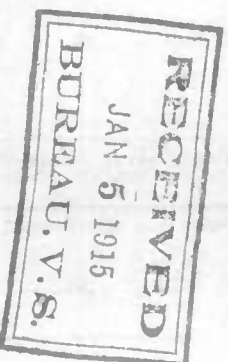
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## 1 PLACE OF DEATH

County WisconsinVillage or City Arnuitland (No. Trappe Dist St; 7 Ward)

## 2 FULL NAME

William F. PriceSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Aug. 27th, 1870  
(Month) (Day) (Year)

7 AGE 44 yrs. 3 mos. 11 ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Merchant  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Worcester Co. Md.

PARENTS  
10 NAME OF FATHER J. Thos. Price  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Amanda F. Causey  
13 BIRTHPLACE OF MOTHER (State or country) Delaware

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta O. Adams(Address) 1004 Fairfax Ave. Norfolk

15 Filed Dec 9, 1914 N. G. Gurner  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 8, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1914, to Dec 8, 1914.

that I last saw him alive on Dec 8, 1914.

and that death occurred on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Embolism

(Duration) 10 yrs. 10 mos. 10 ds.  
Contributory (Secondary) Chronic Valvular Disease  
3 Heart

(Signed) Jos. R. McLaughlin, M. D.  
Dec 9, 1914. (Address) Freightland Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death  yrs. mos. ds. In the State  yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Snow Hill Md. DATE OF BURIAL Dec. 10th, 1914

20 UNDERTAKER Geo. C. Hill ADDRESS Salisbury Md.

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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, U. S.

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1 PLACE OF DEATH 14029

County

Wicomico

Village or City

Salisbury

(No. ....)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

333

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

(Not named)

Robertson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Dec. 3rd

(Month)

(Day)

1914  
(Year)

7 AGE

Dead Born

If LESS than  
1 day, .... hrs.  
0 yrs. .... mos. .... ds. OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Salisbury Md.

PARENTS

10 NAME OF FATHER

J. C. Robertson

11 BIRTHPLACE OF FATHER

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Mary Lou Pitt

13 BIRTHPLACE OF MOTHER

(State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hillaway Robertson

(Address)

Salisbury, Maryland.

15

Filed

Dec. 3, 1914. Gray Turner,

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 3

1914  
(Year)

(Month)

(Day)

17

I HEREBY CERTIFY, That I attended deceased from

1914

to

Rev 15

1914

that I last saw him alive on

Dec 3, 1914

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Sudden

Dead born

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

W. B. B. B.

M. D.

Sec 3

1914

(Address)

Salisbury Md.

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parsons Corn. Salisbury Md.

Dec. 3, 1914.

20 UNDERTAKER

ADDRESS

Geo. C. Hill

Salisbury

Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

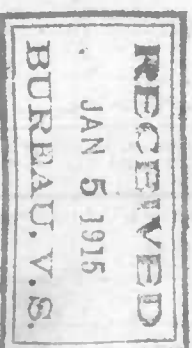
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 14030

County

Wicomico

Village or City

Salisbury

(No. 13

Camden Dist.

St. 13 Ward)

Registration Dist. No.

333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lillis M. Shockley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

ORDIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Oct. 23

(Month)

(Day)

1896 (Year)

7 AGE

18

yrs.

2

mos.

1

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

Delaware

9 BIRTHPLACE

(State or country)

Delaware

PARENTS

10 NAME OF FATHER

Daniel D. Shockley

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sarah J. Evans

13 BIRTHPLACE OF MOTHER

(State or country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel D. Shockley

(Address)

Frankford Super. Co. Del.

15

Filed

Dec. 25, 1914

May Turner

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 24

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 17, 1914, to

Dec. 24, 1914

that I last saw him alive on Dec. 24, 1914

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Peritonitis

(Duration) yrs. mos. 6 ds.

Contributory  
Secondary

Abscess of Kidney

(Duration) yrs. mos. ds.

(Signed)

D. D. Shockley

M. D.

Dec. 25, 1914 (Address) Salisbury Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St. Georges Church  
Dorchester Co. Del.

DATE OF BURIAL

Dec. 26th, 1914

20 UNDERTAKER

Geo. C. Hill

ADDRESS

Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not fully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theuia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 5 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 14031  
 County Wicomico  
 Village or City Near Pottsville (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)  
 Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Pauline R. Smith

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
 (Write the word)

6 DATE OF BIRTH Dec 17, 1914  
 (Month) (Day) (Year)

7 AGE 1 yrs. 2 mos. 27 ds. OR LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work.  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Del

PARENTS  
 10 NAME OF FATHER Walter Smith  
 11 BIRTHPLACE OF FATHER (State or country) Del  
 12 MAIDEN NAME OF MOTHER Florence Smith  
 13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Walter Smith  
 (Address) R. F. D. Willards Md

15 Filed 12/21, 1914 J. Frank Smith  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 17, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1914, to Dec 17, 1914.

that I last saw her alive on Dec 17, 1914.

and that death occurred on the date stated above, at 119, m.

The CAUSE OF DEATH\* was as follows:  
Very large Spinal Bifida since birth.

(Duration) 1 yrs. 2 mos. 27 ds.  
 Contributory Heart Failure  
 Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) O. V. Jassies, M. D.  
Dec 18, 1914 (Address) Greenboro, Del

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted,  
 If not at place of death?  
 Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL at Line Church Del. DATE OF BURIAL 12 18, 1914

20 UNDERTAKER J. Rathiff Harlow ADDRESS unlabeled

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name of organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 5 1915

BUREAU V. S.



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## 1 PLACE OF DEATH

County

Wicomico 13018

92

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 386

Village or City

Delmar

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Arthur J. Sturgis Jr.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

11/23

(Month)

(Day)

1914  
(Year)

7 AGE

0 yrs.1 mos.8 ds.If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Arthur J. Sturgis

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Maud Ed. Sturgis

13 BIRTHPLACE OF MOTHER (State or country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur J. Sturgis

(Address)

Delmar Del.

15

Filed

Jan 1 1915W. J. Linn

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec311914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec - 17th

1914, to

Dec 31st

1914,

that I last saw him alive on Dec 31 1914.

and that death occurred on the date stated above, at \_\_\_\_\_ P. m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration)

yrs.

mos.

13 ds.

Contributory

Secondary

Pneumonia

(Duration)

yrs.

mos.

13 ds.

(Signed)

Robert E. Eliza

, M. D.

Jan 31 1914 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

In the

State

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

\_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Delmar M. PharmacyJanuary 1, 1915

20 UNDERTAKER

ADDRESS

Wm. S. MarvelDelmar Del.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

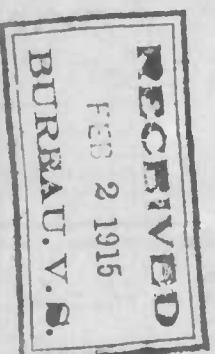
[Approved by U. S. Census and American Public Health Association.]

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*ona, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH <b>14032</b>   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH  |  |
| County <u>Wicomico</u>  |  | Registration Dist. No. <u>333</u>  |  |
| Village or City <u>Near Allen</u> (No. ....)  |  | Trappe Dist. No. <u>7</u> Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |
| 2 FULL NAME <u>Female infant of William E. Twilley</u>  |  |  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |  |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>White</u>                            | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Single</u><br>(Write the word)   |  |
| 6 DATE OF BIRTH <u>Dead born</u><br><u>Dec.</u> (Month) <u>16th</u> (Day) <u>1914</u> (Year)  |  |  |  |
| 7 AGE<br><u>Dead Born</u>   |  | If LESS than 1 day, .... hrs. OR .... min. ?   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>None</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |  |  |  |
| 9 BIRTHPLACE (State or country) <u>Near Allen Wicomico Co. Md.</u>  |  |  |  |
| PARENTS   | 10 NAME OF FATHER <u>William E. Twilley</u>                |  |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |  |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Lillian Hillman</u>            |  |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Samuel E. Twilley</u><br>(Address) <u>Eden Md. Route 2</u>   |  |  |  |
| 15 FILED <u>Dec 16</u> , 1914 <u>N. P. J. Sumner</u><br>REGISTRAR   |  |  |  |
| MEDICAL CERTIFICATE OF DEATH  |  |  |  |
| 16 DATE OF DEATH <u>Dec</u> (Month) <u>16</u> (Day) <u>1914</u> (Year)  |  |  |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>No doctor or midwife</u> , 1914 to <u>Dec 16</u> , 1914, that I last saw him <u>Dead</u> alive on <u>Dec 16</u> , 1914, and that death occurred on the date stated above, at <u>2</u> <u>A</u> . m. The CAUSE OF DEATH* was as follows:<br><u>Dead Born</u> |  |  |  |
| (Duration) .... yrs. .... mos. .... ds.   |  |  |  |
| Contributory<br>Secondary (Duration) .... yrs. .... mos. .... ds.   |  |  |  |
| (Signed) <u>N. P. J. Sumner</u> Local Registrar, M. D.<br><u>Dec 16</u> , 1914 (Address) <u>N. P. J. Sumner</u>   |  |  |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |  |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.<br>Where was disease contracted, if not at place of death?<br>Former or usual residence   |  |  |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>St. Allen M. E. South Church</u>  |  | DATE OF BURIAL<br><u>Dec. 16th</u> , 1914  |  |
| 20 UNDERTAKER <u>Wicomico Co. Ind.</u><br><u>Geo. C. Hull</u>   |  | ADDRESS<br><u>Salisbury</u>  |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

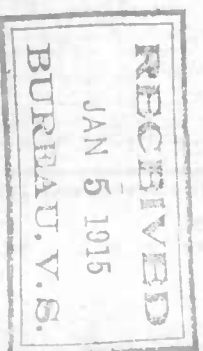
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculous* of *lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|   |  |   |    |             |   |                                   |
|---|--|---|----|-------------|---|-----------------------------------|
| 1 PLACE OF DEATH<br><i>Micomico</i>   |  | 14033   | 92 |             | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |                                   |
| County  |  | Village or City <i>Near Riverton</i>  |    | (No. _____) | St.; _____ Ward)                          | Registration Dist. No. <i>335</i> |
| 2 FULL NAME <i>Nathaniel J Walker</i>   |  |   |    |             |   |                                   |
| PERSONAL AND STATISTICAL PARTICULARS  |  |   |    |             |   |                                   |
| 3 SEX<br><i>Male</i>  | 4 COLOR OR RACE<br><i>White</i>                            | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><i>Widowed</i><br>(Write the word) |    |             |   |                                   |
| 6 DATE OF BIRTH<br><i>Jan 13, 1823</i><br>(Month) (Day) (Year)  |  |   |    |             |   |                                   |
| 7 AGE<br><i>81</i> yrs. <i>11</i> mos. <i>11</i> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?   |  |   |    |             |   |                                   |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <i>House Carpenter</i><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |  |   |    |             |   |                                   |
| 9 BIRTHPLACE (State or country) <i>Micomico</i>   |  |   |    |             |   |                                   |
| PARENTS   | 10 NAME OF FATHER <i>Joseph Walker</i>                     |   |    |             |   |                                   |
|   | 11 BIRTHPLACE OF FATHER (State or country) <i>Micomico</i> |   |    |             |   |                                   |
|   | 12 MAIDEN NAME OF MOTHER <i>Anna Walker</i>                |   |    |             |   |                                   |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i> |   |    |             |   |                                   |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <i>Joseph Walker</i><br>(Address) <i>Riverton Md</i>  |  |   |    |             |   |                                   |
| 15<br>Filed _____, 191____<br>REGISTRAR   |  |   |    |             |   |                                   |
| MEDICAL CERTIFICATE OF DEATH  |  |   |    |             |   |                                   |
| 16 DATE OF DEATH <i>Dec 17, 1914</i><br>(Month) (Day) (Year)  |  |   |    |             |   |                                   |
| 17 I HEREBY CERTIFY, That I attended deceased from <i>Dec 2, 1914</i> to <i>Dec 11, 1914</i><br>that I last saw him alive on <i>Dec 11, 1914</i><br>and that death occurred on the date stated above, at <i>10 a. m.</i><br>The CAUSE OF DEATH* was as follows:<br><i>Pneumonia</i><br>(Duration) _____ yrs. _____ mos. _____ ds.<br>Contributory _____<br>Secondary _____<br>(Duration) _____ yrs. _____ mos. _____ ds.<br>(Signed) <i>H. C. Conway</i> , M. D.<br><i>Dec 2, 1914</i> (Address) <i>Nebraska Md</i><br>*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.<br>18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____<br>19 PLACE OF BURIAL OR REMOVAL <i>Riverton Md</i> DATE OF BURIAL <i>Dec 13, 1914</i><br>20 UNDERTAKER <i>W. D. Gavenor &amp; Son</i> ADDRESS <i>Sharptown</i> |  |   |    |             |   |                                   |



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

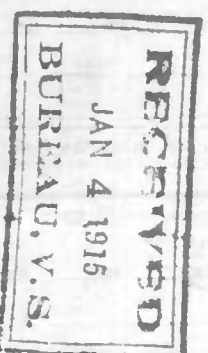
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fertal," "Senile," etc.), "Prosy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUCHAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **14034**  
County Wicomico

Village or City Near Siloam (No. 7 Trappe Dist.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 933

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Still born Infant of Christopher Walter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)

6 DATE OF BIRTH Dec. 23 9 A. M., 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Near Siloam, Wicomico Co., Md.

PARENTS  
10 NAME OF FATHER Christopher Walter  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Mary Smith  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Raymond C. Smith  
(Address) Salisbury, Md.

15 Filed Dec 23, 1914 N P Turner  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 23, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Still Born, 1914 to Dec 23, 1914,  
that I last saw him Still Born Dec 23, 1914,  
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows: No Physician  
No Physician  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) N P Turner Local Registrar, M. D.  
Dec 23, 1914 (Address) Salisbury, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Siloam Cem. Wicomico Co., Md. DATE OF BURIAL Dec 24, 1914  
20 UNDERTAKER Geo. C. Hill ADDRESS Salisbury, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

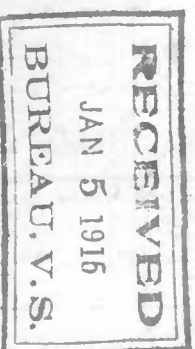
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 14035  
 County Wicomico 28  
 Village or City Salisbury (No. 5, Parsons Dist. St.; 5 Ward)  
 Registration Dist. No. 333  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
 2 FULL NAME E. Jennie Ward

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
 (Write the word)

6 DATE OF BIRTH Dec. 17th, 1862  
 (Month) (Day) (Year)

7 AGE 52 yrs. 0 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Surry Co. Del.

PARENTS  
 10 NAME OF FATHER John C. Wingate  
 11 BIRTHPLACE OF FATHER (State or country) Del.  
 12 MAIDEN NAME OF MOTHER Lucinda C. Parsons  
 13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Wingate  
 (Address) Wilmington, Del.

15 Filed Dec. 24, 1914 May Turner  
Deputy REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 333

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 22, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1914 to Dec 22, 1914,  
 that I last saw her alive on Dec 21, 1914

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
(not detected before death)  
Don't know (Duration) seen by time yrs. mos. ds.

Contributory  
 Secondary (Duration) yrs. mos. ds.

(Signed) John E. Eldredge, M. D.  
Dec 23, 1914 (Address) Salisbury Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
 If not at place of death?  
 Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
O. S. Baptist Church yard Dec. 24, 1914  
Salisbury Md.

20 UNDERTAKERS ADDRESS  
Geo. E. Rill Salisbury  
Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 1915

BUREAU, V. S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1 PLACE OF DEATH <b>14036</b>  |  | (92)   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |
| County <u>Wicomico</u>   |  | Registration Dist. No. _____   |  |   |  |
| Village or City <u>Clara</u>   |  | (No. _____)  |  | St.; _____ Ward)                          |  |
| 2 FULL NAME <u>William Waters</u>  |  |  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |  |  |   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>colored</u>                          | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED<br><u>Married</u><br>(Write the word) |  |   |  |
| 6 DATE OF BIRTH <u>Sept 24</u> , 1880<br>(Month) (Day) (Year)  |  |  |  |   |  |
| 7 AGE <u>34</u> yrs. _____ mos. _____ ds. <u>OR</u> 1 day _____ hrs. _____ min. ?  |  |  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Waterman</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) _____  |  |  |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Maryland</u>  |  |  |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>Nicholas Waters</u>                   |  |  |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |  |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Fannie Farrington</u>          |  |  |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> |  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Charles Hardy</u><br>(Address) <u>Clara Md</u>  |  |  |  |   |  |
| 15 Filed <u>Dec. 27</u> , 1914 <u>L. J. Walter</u><br>REGISTRAR  |  |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |  |  |  |   |  |
| 16 DATE OF DEATH <u>Dec 26</u> , 1914<br>(Month) (Day) (Year)  |  |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 24</u> , 1914, to <u>Dec 25</u> , 1914, that I last saw him alive on <u>Dec 25</u> , 1914, and that death occurred on the date stated above, at <u>9 A</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Peritonitis &amp; abscess</u><br><u>Solar Pneumonia</u><br>(Duration) _____ yrs. _____ mos. <u>10</u> ds.<br>Contributory <u>Deleerium tremens</u><br>Secondary _____<br>(Duration) _____ yrs. _____ mos. <u>7</u> ds.<br>(Signed) <u>J. W. Warner</u> , M. D.<br><u>Dec 26</u> , 1914 (Address) <u>Hauticoby Rd</u><br>*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |  |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.<br>Where was disease contracted, if not at place of death? _____<br>Former or usual residence _____  |  |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Cemetery at Home E Bay</u>  |  |  |  | DATE OF BURIAL <u>Dec 27th</u> , 1914     |  |
| 20 UNDERTAKER <u>C. E. Minnick</u>   |  |  |  | ADDRESS <u>Burglar Md</u>                 |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

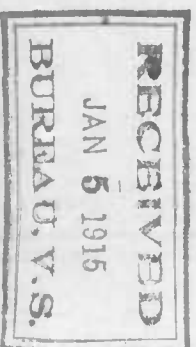
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Toreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 14037  
 County Wicomico 120  
 Village or City Salisbury (No. ...., Salisbury Dist. St. 7 Ward) Registration Dist. No. 333  
 2 FULL NAME Gabriel A. Webster [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
 (Write the word)

6 DATE OF BIRTH Feby. 23rd, 1849  
 (Month) (Day) (Year)

7 AGE 65 yrs. 9 mos. 13 ds. It LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Laborer  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Deals Island Md.

PARENTS  
 10 NAME OF FATHER Loren Webster  
 11 BIRTHPLACE OF FATHER (State or country) Maryland  
 12 MAIDEN NAME OF MOTHER Irmie Wilson  
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Lothian L. Webster  
 (Address) Salisbury Md.

15 Dec 7, 1914 M. Sumner REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 7, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1914, to Dec. 5, 1914, that I last saw him alive on Dec. 3, 1914

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:

Bright Disease (Chronic interstitial nephritis)

(Duration) 10 months yrs. .... mos. .... ds.

Contributory Pulmonary edema  
 Secondary (Duration) .... yrs. .... mos. .... ds.

(Signed) J. M. Cooper, M. D.  
Dec. 7, 1914 (Address) Salisbury Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Deals Island Som. Co. Md. DATE OF BURIAL Dec. 8th, 1914

20 UNDERTAKER Geo. C. Hill ADDRESS Salisbury

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

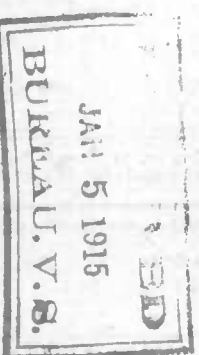
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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecases*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecases* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Wicomico</u>  |  | 14038<br><u>1074</u>  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| Village or City <u>Near Delmar</u>  |  | (No. ....)  |  | Registration Dist. No. <u>386</u>   |  |
|   |  | (St.; .... Ward)  |  | [It death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| 2 FULL NAME <u>Milton Lynch Whalen</u>  |  |   |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |   |  |   |  |
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>White</u>                                    | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Single</u> |  |   |  |
| 6 DATE OF BIRTH <u>Nov. 30th</u> , 19 <u>14</u><br>(Month) (Day) (Year)   |  |   |  |   |  |
| 7 AGE<br><u>0</u> yrs. <u>0</u> mos. <u>23</u> ds. OR <u>1</u> day, <u>...</u> hrs. <u>...</u> min. ?   |  |   |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>None</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>   |  |   |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Near Delmar Md.</u>  |  |   |  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>J. Wesley Whayland</u>                        |   |  |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Wicomico Co. Md.</u> |   |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Leetitia Bailey</u>                    |   |  |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>         |   |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>J. Wesley Whayland</u><br>(Address) <u>Delmar Del.</u>   |  |   |  |   |  |
| 15 Filed <u>12-25</u> , 19 <u>14</u> <u>J. W. Whyland</u><br>REGISTRAR  |  |   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |  |   |  |   |  |
| 16 DATE OF DEATH <u>12 23</u> , 19 <u>14</u><br>(Month) (Day) (Year)  |  |   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 6</u> , 19 <u>14</u> , to <u>Dec 23</u> , 19 <u>14</u> ,<br>that I last saw him alive on <u>Dec 23</u> , 19 <u>14</u> ,<br>and that death occurred on the date stated above, at <u>9 P.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Liver Cirrhosis</u> |  |   |  |   |  |
| (Duration) .... yrs. .... mos. <u>23</u> ds.  |  |   |  |   |  |
| Contributory Secondary <u>None</u><br>(Duration) .... yrs. .... mos. .... ds.   |  |   |  |   |  |
| (Signed) <u>J. W. Whyland</u> , M. D.<br><u>Dec 24</u> , 19 <u>14</u> (Address) <u>Delmar, Md.</u>  |  |   |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |  |   |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence.....  |  |   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Parsons Cem. Salisbury Md.</u> DATE OF BURIAL <u>Dec. 25th</u> , 19 <u>14</u>  |  |   |  |   |  |
| 20 UNDERTAKER <u>Geo. C. Hill</u> ADDRESS <u>Salisbury Md.</u>  |  |   |  |   |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 14030  
 County Victoria 120  
 Village or City Helmar (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Louise Bord. Whitson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
 (Write the word)

6 DATE OF BIRTH 9 18 1839  
 (Month) (Day) (Year)

7 AGE 75 yrs. 3 mos. 1 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work House Wife.  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Indiana, Wane Co

PARENTS  
 10 NAME OF FATHER Unknown  
 11 BIRTHPLACE OF FATHER (State or country) Unknown  
 12 MAIDEN NAME OF MOTHER Unknown  
 13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) George W. Whitson  
 (Address) Helmar Del R40 #3

15 Filed 12/21, 1914 J. J. [unclear] REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 19 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1914, to Dec 19, 1914, that I last saw him alive on Dec 19, 1914.

and that death occurred on the date stated above, at P. R. m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart Trouble

(Duration) 5 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory Chronic nephritis  
 Secondary

(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) [Signature], M. D.  
Dec 19, 1914 (Address) Helmar Del.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Melrose N.E. Cemetery DATE OF BURIAL 12 21 1914  
 20 UNDERTAKER H. O. Carson ADDRESS Whitsonville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JAN 5 1915  
BUREAU U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH *St. E. Hospital* STATE OF MARYLAND  
 County *Washington* CERTIFICATE OF DEATH  
 Registration Dist. No. *333*  
 Village or City *Salisbury* (No. *20*) *Candor Dist* St.; *13* Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Charles William*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*  
 (Write the word)

6 DATE OF BIRTH *unknown*  
 (Month) (Day) (Year)

7 AGE *6* If LESS than 1 day, hrs. OR min. ?  
 yrs. mos. ds.

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work. *none*  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Somerset Co. Md*

10 NAME OF FATHER *Lambert Williams*

11 BIRTHPLACE OF FATHER (State or country) *Somerset Co. Md*

12 MAIDEN NAME OF MOTHER *Laura Williams*

13 BIRTHPLACE OF MOTHER (State or country) *Somerset Co. Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *James D. Turner*  
 (Address) *Principals Ave. Md*

15 Filed *Dec 10*, 1914. *N. P. Turner*  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 10*, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Dec 8*, 1914, to *Dec 9*, 1914,  
 that I last saw him alive on *Dec 9*, 1914

and that death occurred on the date stated above, at *10* m.

The CAUSE OF DEATH\* was as follows:

*Infection of face, throat, head, brain, etc. Streptococci*  
 (Duration) *about* mos. *14* ds.

Contributory *Infection from a tooth*  
 Secondary (Duration) yrs. mos. ds.

(Signed) *J. M. C.*, M. D.  
*Dec 10*, 1914 (Address) *Salisbury, Md*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death yrs. mos. ds. In the State *Hyattsville* yrs. mos. ds.

Where was disease contracted, If not at place of death? *Somerset Co. Md*  
 Former or usual residence *Somerset Co. Md*

19 PLACE OF BURIAL *Curtis Chapel* DATE OF BURIAL *Dec 19*, 1914

20 UNDERTAKER *James D. Turner* ADDRESS *P. Anne*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

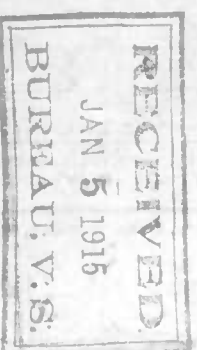
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not fully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Wicomico

Village or City Salisbury (No. 28, Salisbury Wit. 9th St.; 9th Ward)

2 FULL NAME Millie Williams

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Feb. 21st 1898  
(Month) (Day) (Year)

7 AGE 46 yrs 9 mos 25 ds It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Somerset Co. Md.

PARENTS  
10 NAME OF FATHER George Harner  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Not known  
13 BIRTHPLACE OF MOTHER (State or country) ??

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Hitchens

(Address) Salisbury Md.

15 Filed Dec 16, 1914 N. P. Turner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 16, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1914, to Dec 16, 1914

that I last saw him alive on Dec 16, 1914

and that death occurred on the date stated above at 12 A. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis Pulmonary

(Duration) not known yrs. several mos. ds.

Contributory  
Secondary Exhaustion

(Duration) yrs. mos. ds.

(Signed) M. D.

Dec 16, 1914 (Address) Salisbury Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 3 P.M.

Mad Point M. E. Churchyard Dec. 18th, 1914

20 UNDERTAKER ADDRESS

Geo. C. Hill Salisbury

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

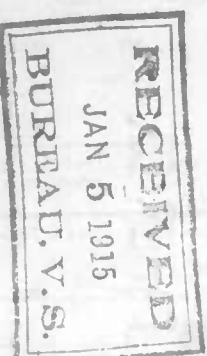
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1914  
46  
1908



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4042

County MeimianVillage or City Bivale (No. 154) St.; WardSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 337

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charlotte Willing

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Dec 24, 1840  
(Month) (Day) (Year)

7 AGE 74 yrs. 5 mos. 5 ds. IF LESS than  
1 day.....hrs. OR.....min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Thomas Murray11 BIRTHPLACE OF FATHER (State or country) don't know12 MAIDEN NAME OF MOTHER Murray Murray13 BIRTHPLACE OF MOTHER (State or country) don't know

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Gertie Evans(Address) Fectorville Md

15 Filed Dec 31, 1914 L. T. Walter  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 28, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
....., 191....., to ..... , 191.....

that I last saw h..... alive on....., 191.....

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH\* was as follows:

No physician in attendance.  
Dead of long infirmities of old age.  
Declining for some time  
(Duration) ..... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) ..... yrs. .... mos. .... ds.  
(Signed) L. T. Walter, Local Registrar, M. D.  
Dec. 31, 1914. (Address) Pantopske, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

John Haskins Dec 31, 1914  
20 UNDERTAKER not removing ADDRESS Waverly  
G. E. Herring

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., or..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Propsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 5 1915

BUREAU. V. S.

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|  |   |   |  |
|--|---|---|--|
| 1 PLACE OF DEATH <b>14043</b> <b>(92)</b>  |   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| County <b>Wicomico</b>   |   | Registration Dist. No. <b>333</b>   |  |
| Village or City <b>Salisbury</b> (No. <b>Camden</b> St.; <b>13</b> Ward)   |   | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| 2 FULL NAME <b>James H. Willing</b>  |   |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |  |
| 3 SEX<br><b>male</b>   | 4 COLOR OR RACE<br><b>White</b>                       | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><b>married</b><br>(Write the word)                 |  |
| 6 DATE OF BIRTH<br><b>do not know month</b><br>(Month) (Day) (Year) <b>1857</b>  |   |   |  |
| 7 AGE<br><b>57</b> yrs. mos. ds.   |   | If LESS than 1 day, hrs. OR min. ?  |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <b>Day Laborer</b><br>(b) General nature of industry, business, or establishment in which employed (or employer)   |   |   |  |
| 9 BIRTHPLACE (State or country) <b>Del</b>   |   |   |  |
| PARENTS  | 10 NAME OF FATHER <b>Charles Willing</b>              |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <b>Del</b> |   |  |
|  | 12 MAIDEN NAME OF MOTHER <b>do not know</b>           |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or country) <b>L</b>   |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <b>Clifton J. Willing</b><br>(Address) <b>Salisbury, Md</b>  |   |   |  |
| 15 <b>Dec 28</b> , 1914 <b>N. Turner</b><br>REGISTRAR  |   |   |  |
| MEDICAL CERTIFICATE OF DEATH   |   |   |  |
| 16 DATE OF DEATH <b>Dec 26</b> , 1914<br>(Month) (Day) (Year)  |   |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <b>Dec 22</b> , 1914, to <b>Dec 25</b> , 1914.  |   |   |  |
| that I last saw him alive on <b>Dec 25</b> , 1914  |   |   |  |
| and that death occurred on the date stated above, at <b>11:30 a.m.</b>   |   |   |  |
| The CAUSE OF DEATH* was as follows:<br><b>Pneumonia</b>  |   |   |  |
| (Duration) <b>4</b> yrs. mos. ds.  |   |   |  |
| Contributory Secondary   |   |   |  |
| (Signed) <b>Harry C. Lee</b> , M. D.<br><b>Dec 28</b> , 1914 (Address) <b>Salisbury</b>  |   |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |   |   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)<br>At place of death yrs. mos. ds. In the State yrs. mos. ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence. |   |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><b>Roberts Cemetery</b>   |   | DATE OF BURIAL<br><b>Dec 28</b> , 1914  |  |
| 20 UNDERTAKER<br><b>Halloway &amp; Co</b>  |   | ADDRESS<br><b>Salisbury, Md</b>   |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

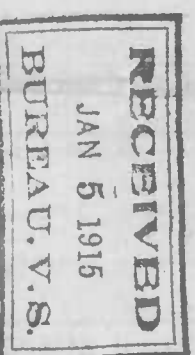
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

14044

91

County WicomicoSalisbury Dist.STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury (No. 208, Halloware St.; 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Scott E Wright

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE a a 5 SINGLE, single  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

6 DATE OF BIRTH Sept 30, 1914  
(Month) (Day) (Year)

7 AGE 2 5 If LESS than  
1 day.....hrs.  
yrs. mos. ds. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work not any  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Maryland

## PARENTS

## 10 NAME OF FATHER

Scott Wright11 BIRTHPLACE OF FATHER  
(State or country)Maryland

## 12 MAIDEN NAME OF MOTHER

Elean Roberts13 BIRTHPLACE OF MOTHER  
(State or country)Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elean Roberts

(Address)

Salisbury, Md.

## 15

Filed Dec. 8, 1914. May Turner,  
Deputy REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 6, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1914, to Dec. 6, 1914.

that I last saw him alive on Dec. 5, 1914.

and that death occurred on the date stated above, at 6 A m.

The CAUSE OF DEATH\* was as follows:

Capillary Pneumonia(Duration) yrs. mos. 4 ds.Contributory  
SecondaryConvulsions(Duration) yrs. mos. 1 ds.

(Signed)

W B Potter, M. D.Dec 7, 1914 (Address) Salisbury, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Houston Cemetery Dec 8, 1914

## 20 UNDERTAKER

## ADDRESS

E. H. Stewart Salisbury, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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RECEIVED

JAN 5 1915

BUREAU, V. S.